City of Carson City
Agenda Report

Date Submitted: 5-29-12

Agenda Date Requested: 6-7-12
Time Requested: 10 minutes

To: Board of Supervisors

From: Melanie Bruketta, HR Director

Subject Title: (For Possible Action) Action to approve the employee health insurance plan with St. Mary's HealthFirst, the employee dental and life insurance plans with The Standard and the employee vision plan with VSP. (Melanie Bruketta)

Staff Summary: This action is to approve the benefit plans for health, dental, life and vision for active city employees and retirees. All plans will go from a 3-tier level of coverage to a 4-tier level of coverage. Standard has agreed to increase the dental coverage for major services from 50% to 55% without an increase in rates, but due to the 4-tier rate structure, the rate for family coverage will increase from $115.75 to $124.72. The other rates will either remain the same or decrease.

Vision insurance is covered by VSP. There is a also a slight change in the VSP rates, but the changes do not affect employee only and employee plus spouse coverage.

The health plan will have the following rate increases: HMO- 7.13%, POS- 5.07% and PPO- employee without Medicare 6.5%, employee and spouse with Medicare 2% and employee plus family 18%. In addition, a Domestic Partner Rider is included in the renewal.

Type of Action Requested: (check one)

Type of Action Requested: (check one)

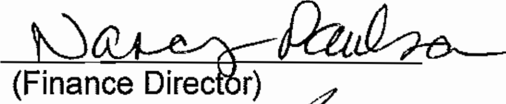
(__) Resolution
(__) Ordinance
(X)Formal Action/Motion
(__) Other (specify)

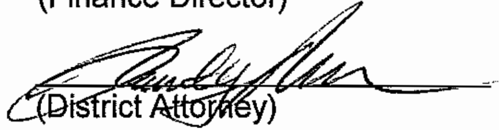
Does this Action Require a Business Impact Statement: (__)Yes (X) No

Recommended Board Action: I move to approve the employee health insurance plan with St. Mary's HealthFirst, the employee dental and life

Prepared By: Melanie Bruketta, HR Director

Reviewed By: Date: 5/29/12
(City Manager)

 Date: 5/29/12
(Finance Director)

 Date: 5/29/12
(District Attorney)

Board Action Taken:

Motion(s):______________________ 1)____________ Aye/Nays

2)____________ ____________

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(Vote Recorded By)

CARSON CITY
ESTIMATED HEALTH CARE COSTS FOR FY2013
PREPARED ON MAY 8, 2012

	HMO												
	CCEA			Unclassified			Sheriff's Office			Firefighters			
	# of EE's	Rate	Cost per month	# of EE's	Rate	Cost per month	# of EE's	Rate	Cost per month	# of EE's	Rate	Cost per month	Total # of Employees
Self													
Medical	95.39	453.32	43,242.19	85	453.32	38,532.20	29	453.32	13,146.28	8	453.32	3,626.56	217.39
Dental		57.08	5,444.86		57.08	4,851.80		57.08	1,655.32		57.08	456.64	
Vision		6.61	630.53		6.61	561.85		6.61	191.69		6.61	52.88	
Life/AD&D		9.00	858.51		9.00	765.00		20.90	606.10		8.60	68.80	
Self + Spouse													
Medical	36	929.30	33,454.80	17	929.30	15,798.10	2	929.30	1,858.60	7	929.30	6,505.10	62.00
Dental		80.59	2,901.24		80.59	1,370.03		80.59	161.18		80.59	564.13	
Vision		8.59	309.24		8.59	146.03		8.59	17.18		8.59	60.13	
Life/AD&D		9.30	334.80		9.30	158.10		21.20	42.40		8.90	62.30	
Cost per EE			(8,206.56)			(4,265.05)			(501.77)			(878.10)	
Self + Child													
Medical	38	869.92	33,056.96	10	869.92	8,699.20	5	869.92	4,349.60	3	869.92	2,609.76	56.00
Dental		101.52	3,857.76		101.52	1,015.20		101.52	507.60		101.52	304.56	
Vision		10.26	389.88		10.26	102.60		10.26	51.30		10.26	30.78	
Life/AD&D		9.30	353.40		9.30	93.00		21.20	106.00		8.90	26.70	
Cost per EE			(8,662.48)			(2,324.95)			(1,162.48)			(348.74)	
Family													
Medical	44	1,420.69	62,510.36	25	1,420.69	35,517.25	24	1,420.69	34,096.56	18	1,420.69	25,572.42	111.00
Dental		124.72	5,487.68		124.72	3,118.00		124.72	2,993.28		124.72	2,244.96	
Vision		16.39	721.16		16.39	409.75		16.39	393.36		16.39	295.02	
Life/AD&D		9.30	409.20		9.30	232.50		21.20	508.80		8.90	160.20	
Cost per EE			(16,327.52)			(13,063.63)			(12,541.08)			(4,702.91)	
Total Estimated Cost Per Bargaining Unit			232,206.65			138,814.04			83,875.07			63,542.29	559.39
Less Employee dependent deferral			(39,315.07)			(25,444.56)			(20,555.29)			(8,995.88)	
Total Fiscal Impact			192,891.58			113,369.48			63,319.79			54,546.41	

CARSON CITY
ESTIMATED HEALTH CARE COSTS FOR FY2013
PREPARED ON MAY 8, 2012

	Retiree's									
	HMO			PPO			Out of Area			
	# of EE's	Rate	Cost per month	# of EE's	Rate	Cost per month	# of EE's	Rate	Cost per month	
Retiree & Family w/out Medicare										
Medical		1,420.69	-	1	1,465.17	1,465.17		1,829.24	-	1.00
Dental		124.72	-		124.72	124.72		124.72	-	
Vision		16.39	-		16.39	16.39		16.39	-	
Life/AD&D		4.80	-		4.80	4.80		4.80	-	
Retiree & Family two with Medicare										
Medical		848.75	-		871.08	-		1,053.86	-	-
Dental		124.72	-		124.72	-		124.72	-	
Vision		16.39	-		16.39	-		16.39	-	
Life/AD&D		4.80	-		4.80	-		4.80	-	
Retiree & Family, one with Medicare										
Medical	1	994.12	994.12		1,022.09	-		1,250.95	-	1.00
Dental		124.72	124.72		124.72	-		124.72	-	
Vision		16.39	16.39		16.39	-		16.39	-	
Life/AD&D		4.80	4.80		4.80	-		4.80	-	
Total Estimated Retiree Cost Per Selected Plan			27,049.78			34,734.62			2,926.27	113.00

	Monthly	Annual
Total Premiums	583,148.72	6,997,785
Employee dependent deferral	(94,310.80)	(1,131,730)
Retirees Subsidy	(16,752.80)	(201,034)
Total Estimated Fiscal Impact	(16,752.80)	5,665,022

1) Estimated number of employees per class obtained from HR department during negotiations, for breakout of employee plus child, and adjusted slightly to match Lockton Report, and 2013 budget full time equivalents estimate for 2012.
2) Rates obtained from final Lockton Reports, and final rates received from St. Mary's on 4 tier basis.
3) Retiree Subsidy estimated from Retiree Listing updated as of June 30, 2011. (most current I had)

II. Introduction

This Group Contract, any amendments, attachments, including the Evidence of Coverage ("EOC") document(s) and any applicable Riders, the application of the employer, the enrollment forms of individual employees and amendments to any of them incorporated by reference herein, shall constitute the entire agreement between Saint Mary's HealthFirst and City of Carson City.

The Employer or any individual Member is not authorized to make any promises or representations or warranties concerning HealthFirst's services, facilities or supplies provided under the Contract. Any statements by an Employer or the Employer's representative concerning the services provided by HealthFirst or under the EOC shall not be binding on HealthFirst. As such, no such statement shall be used in support of a benefit claim under this Contract unless it is approved in writing by HealthFirst. Pursuant to this Contract, HealthFirst shall provide covered services and supplies to Members in accord with the EOC document(s).

No agent or employee of HealthFirst is authorized to change the form or content of this Contract. Any changes to this Contract can be made only through an endorsement authorized and signed by an officer of HealthFirst.

III. Products

List each product available from the plan and the appropriate EOC

Benefit Plan OHCARSON AND OPCARSON

Riders Rx $10/30/50D

IV. Term of Contract

This Contract becomes effective on July 1, 2011 at 12:00 a.m. Pacific Time and will remain in effect for a term of 12 consecutive months, until June 30, 2012 (the "Termination Date") unless terminated as set forth in the Termination of Contract section. Except as expressly provided in any EOC document(s) incorporated in this Contract, all rights to benefits under this Contract end at 11:59 p.m. on the Termination Date.

V. Termination of Contract

The employer may terminate this Contract by providing HealthFirst with a written notice of its intent to terminate this contract at least sixty (60) days in advance of the proposed termination date. HealthFirst may terminate or not renew this Contract for good cause as set forth below.

4. **Failure to meet Participation and Contribution requirements**
Failure of the employer to maintain minimum subscription charge contribution requirements or minimum participatory requirements or as stated in the group requirements set forth in the Master Application (see Section VII, item L of this contract).

Group will allow HealthFirst to review and audit payroll and other pertinent records for the verification of eligibility of employees as stated in contributions or group requirements. HealthFirst will make written and verbal request to Group and conduct all such reviews during regular business hours.

Group agrees to pay % for employees and % for an employee's dependents.

5. **Discontinuance of a product or all products within a market**
HealthFirst may terminate a particular product or all products offered in a small or large group market, if it discontinues offering insurance in the geographic area of the state where the employer is located. HealthFirst may also discontinue the issuance and renewal of coverage to a small employer if the Nevada Insurance Commissioner finds that the continuation of coverage would not be in the best interest of the policyholders or certificate holders or would impair the ability of the carrier to meet its contractual obligations. If the Commissioner makes such a finding, the Commissioner shall assist the affected small employers in finding replacement coverage. HealthFirst may also discontinue products offered to small employers if the Nevada Insurance Commissioner finds that the form of the product offered by HealthFirst is obsolete and is being replaced with comparable coverage. HealthFirst will notify the Commissioner and the Chief Regulatory Officer for insurance in each state in which it is licensed of its decision to discontinue the issuance or renewal of a product at least sixty (60) days before HealthFirst notifies the affected small employers. HealthFirst will notify affected employers at least one hundred eighty (180) days before the date on which it will discontinue offering the product and it will offer each affected small employer the option to purchase any other health benefit plan currently offered by it to small employers in Nevada. In exercising its option to discontinue the product and in offering the option to purchase other coverage, HealthFirst will act uniformly without regard to the claims experience of the affected small employers or any health status-related factor relating to any participant or beneficiary covered by the discontinued product or any new beneficiary who may become eligible for such coverage. HealthFirst will comply with the requirements of NRS 689C.310-.320 and NRS 689B.560 if it decides to discontinue providing insurance in a geographic area or discontinue products to the small employer market.

6. **A Material change in the nature of the Employer's Business, i.e.,**
   - Dropping under 2 employees
   - Sale of business
   - Change in contribution level
   - Other significant changes in the composition or status of the employer's business.

Employees who request special enrollment must do so no later than thirty (30) days after the loss of the other creditable coverage. Special enrollment is effective on the first day of the calendar month beginning after the date the completed enrollment request is received by HealthFirst.

C. Dependents include:

1. employee's lawful spouse;

2. For Qualified Plans, be a Member's child who is not yet 26; or

   For Grandfathered Plans, be a Member's child who is not yet 26 and who is not otherwise covered by other employer provided health plan coverage;

3. Unmarried children over the age of 25, who are chiefly dependent upon the employee for support due to mental illness, developmental disability, mental retardation or physical handicap.

4. The term child includes natural children, step-children, and children for whom You have been appointed by the court as permanent legal guardian, or children who have been legally adopted or are awaiting finalization of adoption by You.

D. All eligible employees must permanently reside or perform employment duties within the HealthFirst Service Area.
The service area includes the following communities:

HMO
All communities of Washoe County
The greater Carson City area
The Churchill County area
The Eureka County area
The Elko County area
The Lander County area
The Mineral County area
The Pershing County area
The White Pine County area
The Lyon County communities of: Dayton, Fernley, Silver City, and Silver Springs
The Douglas County communities of: Gardnerville, Genoa, and Minden, Stateline
The Storey County community of Virginia City and Virginia City Highlands

E. All eligible employees must satisfy any probationary or waiting period requirements established by the Group:

first of month following ninety (90) days of employment

The Group may be required to continue coverage for an employee or dependent who has lost eligibility within the Group. The specific option for continuation will be determined by the individual employee or dependent qualifying event as detailed in the EOC. The employee and their dependents will be terminated off of the group plan on the after termination of employment.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage
HealthFirst recognizes that many employers must comply with the continuation of group coverage requirements of federal laws and regulations, which collectively are commonly referred to as Consolidated Omnibus Budget Reconciliation Act (COBRA) (hereinafter referred to as "COBRA"). HealthFirst acknowledges that employers who are so affected cannot discharge their legal obligations without HealthFirst's informed and willing participation in providing the continuation coverage.
HealthFirst is therefore committed to the following:

A. Maintaining awareness of continuation coverage requirements of the Internal Revenue Code, the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, and regulations, which are issued by the Secretaries of these agencies.

B. Providing continuation coverage to Members upon the request of an employer when such requests are consistent with the employer's obligations under the law.

C. Sharing knowledge regarding COBRA with employers as they experience problems but HealthFirst will not give legal advice on these matters.

Members who are hospitalized on the date coverage under this Contract ends, may be eligible for continuation of coverage. See "Conversion Privilege and Transfer" and "Extension of Benefits" in the EOC.

Termination of this Contract, other than for Nonpayment of Premiums (see "Termination due to Nonpayment") or Fraud, shall become effective upon sixty (60) days written notice to the employer.

If this Contract terminates under its own terms, or is otherwise terminated by either HealthFirst or employer, the employer shall promptly mail or hand deliver to each Member covered hereunder, a notice of cancellation of this Contract. The employer shall, upon request by HealthFirst, provide HealthFirst a copy of the notification, a written statement that the notice of cancellation was mailed or hand delivered to each Member, and the date of mailing or hand delivery.

C. Premium adjustments required as a result of terminations or new hires will be applied by HealthFirst to the Premium Billing subsequent to the receipt of the required HealthFirst forms and notifications procedures. Retroactive payment adjustments will be made in subsequent billing statements for any additions or terminations of Members not reflected in HealthFirst's records at the time of calculation of Premium charges.

In order for a credit of Premium charges to be applied for terminated members, HealthFirst must receive notification as soon as possible following the date of the Member's ineligibility, but in no event later than sixty (60) days following such date. HealthFirst will credit a maximum of sixty (60) days of Premium charges to the employer for ineligible Members.

It is the sole responsibility of the Group to review the Total Monthly Premium each month, ensure it accurately reflects any and all Member terminations, and bring any discrepancies to the attention of HealthFirst within sixty (60) days of the Member's ineligibility.

Only Members for whom payment is received by HealthFirst shall be eligible for services and benefits hereunder and only for the period covered by such payment. If any Member covered hereunder is terminated by HealthFirst, prepaid Premiums received on account of the terminated Member or Members applicable to periods after the effective date of the termination will be credited back to the employer on the next following billing statement, and neither HealthFirst nor any physician group has any further liability or responsibility under this Contract to such terminated Member.

In the foregoing instances where a Member is being retroactively terminated by the group, the effective date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Member under this Contract. In such instances the date of termination will be the first day of the calendar month following the month in which services or supplies were provided, and any applicable credit of premium charges will be calculated from that date.

If the employer seeks to retroactively add Members, enrollment forms must be received by HealthFirst as soon as possible following the Member's eligibility date, but in no event later than sixty (60) days following such date. HealthFirst will charge the employer retroactive premiums according to the Member's effective date, which will be calculated using rules established by HealthFirst for determining effective dates of retroactive adjustments, but in no event will the effective date be more than sixty (60) days prior to when HealthFirst receives the enrollment forms.

D. Group shall submit to HealthFirst all enrollment, termination and/or change of status forms within thirty one (31) days of event, but in no case shall credits to remittances be for a premium period (month) of more than sixty (60) days from the date of the event.

E. In situations that include, but are not limited to those found in Section V, item 6, HealthFirst reserves the right to change the Total Monthly Premium for the health benefits plan and/or Riders upon sixty (60) days written notice, provided such changes are in accordance with the provisions set forth in the Evidence of Coverage.

I. **Delegation of Claims review authority**
HealthFirst is a named fiduciary to review claims under this Contract. Group delegates to HealthFirst the discretion to construe and interpret the terms of the EOC and other disclosure statements as well to determine whether a Member is eligible for benefits. In making these determinations, HealthFirst has authority to review claims in accordance with the procedures contained in the EOC and herein, and to construe this Contract to determine whether the Member is entitled to benefits.

J. **Member Information**
Group will inform enrollees of eligibility requirements for Members and when coverage becomes effective and terminates.

If HealthFirst gives Group any information that is material to Members, Group will disseminate that information to Members by the next regular communication to them, but in no event later than thirty (30) days after Group receives the information. For purposes of this paragraph, "material" means information that a reasonable person would consider important in determining action to be taken.

K. **No Waiver**
HealthFirst's failure to enforce any provision of this Contract will not constitute a waiver of that or any other provision, or impair HealthFirst's right thereafter to require Group's strict performance of any provision.

L. **Notices**
Notices from HealthFirst to Group or from Group to HealthFirst must be mailed to the address indicated on the signature page of this Contract except that HealthFirst and Group may change its notice address by giving written notice to the other. Notices are deemed given when deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

M. **Right to Examine Records**
Upon reasonable notice, HealthFirst may examine Group's records with respect to eligibility and payments under this Contract.

N. **Successors and Assignees**
Benefits and obligations of this Contract are binding on the successors and permitted assignees of HealthFirst and Group.

O. **Non-discrimination**
HealthFirst and the employer hereby agree that no person who is otherwise eligible for coverage under this Contract shall be refused enrollment nor shall their coverage be cancelled solely because of race, color, national origin, ancestry, religion, sex, marital status, age, health status, or physical or mental handicap.

P. **Notice of Certain Events**
HealthFirst will give the employer written notice, within a reasonable time, of any termination or breach of Contract, or inability to perform services, by a Physician Group

Signature Page

When notice is required under this Contract, it shall be sent prepaid, first class US mail to:

HealthFirst:

Sales and Marketing Department
Saint Mary's HealthFirst
1510 Meadow Wood Lane
Reno, Nevada 89502

Group:

Robert L. Crowell
City of Carson City
201 North Carson Street, No. 4
Carson City, Nevada 89701

Mediation before Litigation
Group and Saint Mary's HealthFirst agree to first mediate prior to resort to the courts, the disputes described below pursuant to the procedures set forth herein. Group understands that each Member/Enrollee's participation in mediation before litigation is completely voluntary, and that by agreeing to mediate disputes relating to the EOC, the Health Plan or health care services provided by Saint Mary's HealthFirst, the Member/Enrollee has not foregone their right to resolve any such dispute in a court of law or equity. Group agrees that any claim Group may assert for alleged violation of any duty to a Member arising out of this Contract, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this Contract, irrespective of legal theory, shall be resolved by first submitting the dispute to mediation which shall be conducted by JAMS/Endispute (916) 921-5300. In the event the dispute is not resolved through mediation, the dispute shall be resolved in a court of law or equity.

For Saint Mary's HealthFirst:

Name: Dave Challis

Title: Vice President and CFO

Date 7/1/11

For Group: City of Carson City

Name: Robert L. Crowell

Title: Mayor

Date 6·28·11

This is one (1) of two (2) originals

Saint Mary's HealthFirst

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's HealthFirst and City of Carson City.

Section **III. Products** is amended to read as such:

List each product available from the plan and the appropriate EOC

Benefit Plan HMOB 100% 3030 and 1500 POS 1030/2040

Riders Rx $10/40/60D

Section **IX. Premium Payment**, part A is amended to read as such:

A. Group agrees to remit to HealthFirst the Total Monthly Premium on behalf of each eligible employee who has enrolled in the health benefit plan, in accordance with the Class of Contract and Total Monthly Premium listed herein. Where applicable, any contribution required by the employee will be collected through payroll deduction or other such program by the Group. Only Members for which the HealthFirst has received the appropriate payment are entitled to services and supplies.

HMOB 100% 3030					**Total Monthly**
Tier	**Medical**	**Rx**	**Dental**	**Vision**	**Premium**
Employee	$366.50	$81.30	$0.00	$0.00	$447.80
Employee & Spouse	$751.32	$166.66	$0.00	$0.00	$917.98
Employee & Child(ren)	$703.31	$156.01	$0.00	$0.00	$859.32
Employee & Family	$1,148.60	$254.79	$0.00	$0.00	$1,403.39
					Total Monthly
Tier: Retiree	Medical	Rx	Dental	Vision	Premium
Single without Medicare	$366.50	$81.30	$0.00	$0.00	$447.80
Single with Medicare	$243.66	$81.30	$0.00	$0.00	$324.96
Retiree & Spouse w/o Medicare	$751.32	$166.66	$0.00	$0.00	$917.98
Retiree & Spouse both w/ Medicare	$523.47	$166.66	$0.00	$0.00	$690.13
Retiree & Spouse one w/ Medicare	$655.44	$166.66	$0.00	$0.00	$822.10
Retiree & Child(ren) w/o Medicare	$703.31	$156.01	$0.00	$0.00	$859.32
Retiree & Child(ren) w/ Medicare	$692.98	$156.01	$0.00	$0.00	$848.99
Retiree & Family w/o Medicare	$1,148.60	$254.79	$0.00	$0.00	$1,403.39
Retiree & Family two with Medicare	$576.66	$254.79	$0.00	$0.00	$831.45
Retiree & Family one with Medicare	$722.03	$254.79	$0.00	$0.00	$976.82

Saint Mary's HealthFirst

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's HealthFirst and City of Carson City.

Section **III. Products** is amended to read as such:

List each product available from the plan and the appropriate EOC

Benefit Plan HMOB 100% 3030 and 1500 POS 1030/2040

Riders Rx $10/40/60D

Section **IX. Premium Payment**, part A is amended to read as such:

A. Group agrees to remit to HealthFirst the Total Monthly Premium on behalf of each eligible employee who has enrolled in the health benefit plan, in accordance with the Class of Contract and Total Monthly Premium listed herein. Where applicable, any contribution required by the employee will be collected through payroll deduction or other such program by the Group. Only Members for which the HealthFirst has received the appropriate payment are entitled to services and supplies.

HMOB 100% 3030

Tier	Medical	Rx	Dental	Vision	Total Monthly Premium
Employee	$366.50	$81.30	$0.00	$0.00	$447.80
Employee & Spouse	$751.32	$166.66	$0.00	$0.00	$917.98
Employee & Child(ren)	$703.31	$156.01	$0.00	$0.00	$859.32
Employee & Family	$1,148.60	$254.79	$0.00	$0.00	$1,403.39
Tier: Retiree	Medical	Rx	Dental	Vision	Total Monthly Premium
Single without Medicare	$366.50	$81.30	$0.00	$0.00	$447.80
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Retiree & Spouse both w/ Medicare	$523.47	$166.66	$0.00	$0.00	$690.13
Retiree & Spouse one w/ Medicare	$655.44	$166.66	$0.00	$0.00	$822.10
Retiree & Child(ren) w/o Medicare	$703.31	$156.01	$0.00	$0.00	$859.32
Retiree & Child(ren) w/ Medicare	$692.98	$156.01	$0.00	$0.00	$848.99
Retiree & Family w/o Medicare	$1,148.60	$254.79	$0.00	$0.00	$1,403.39
Retiree & Family two with Medicare	$576.66	$254.79	$0.00	$0.00	$831.45
Retiree & Family one with Medicare	$722.03	$254.79	$0.00	$0.00	$976.82

Saint Mary's HealthFirst

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Amendment to the Group Contract is executed by and between Saint Mary's HealthFirst and City of Carson City.

Section **VII. Eligibility and Enrollment of Members,** Part E reads as:

All eligible employees must satisfy any probationary or waiting period requirements established by the Group:

First of month following ninety (90) days of employment

Section **VII. Eligibility and Enrollment of Members,** Part E amended to read as follows:

All eligible employees must satisfy any probationary or waiting period requirements established by the Group:

First of month following ninety (90) days of employment
Rehires: no waiting period for any employee laid off and rehired within a year.

This amendment will become effective April 1, 2012.

For: Saint Mary's HealthFirst	For: City of Carson City
[signature]	______________________
Name: Dave Challis	Name: Robert L. Crowell
Title: Vice President and CFO	Title: Mayor
	Date:______________________

This is one (1) of two (2) originals

JT

Saint Mary's HealthFirst

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's HealthFirst and City of Carson City.

Section **III. Products** is amended to add:

List each product available from the plan and the appropriate EOC

Riders Domestic Partner Rider

Section **VII. Eligibility and Enrollment**, part C is amended to read as such:

A. Dependents include:

1. employee's lawful spouse; or certified domestic partner:

This amendment is effective from:

July 1, 2012

For: Saint Mary's HealthFirst	For: City of Carson City
[signature]	______________________
Name: Dave Challis	Name: Robert L. Crowell
Title: Vice President and CFO	Title: Mayor
	Date ______________________

This is one (1) of two (2) originals

Saint Mary's HealthFirst

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's HealthFirst and City of Carson City.

Section **VII. Eligibility and Enrollment of Members** is amended to include the following:

L. A Retiree Benefit Program is permissible under the parameters of the following criteria:

- City of Carson Police and Fire are eligible for retirement after 25 years of service

- All other City of Carson Employees are eligible for retirement after 30 years of service

The Total Monthly Premium rates for Retirees, shown in Section **IX. Premium Payment** are effective from:

July 1, 2012 - June 30, 2013

For: Saint Mary's HealthFirst

Name: Dave Challis

Title: Vice President and CFO

For: City of Carson City

____

Name: Robert L. Crowell

Title: Mayor

Date ____________________

This is one (1) of two (2) originals

Saint Mary's HealthFirst

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's HealthFirst and City of Carson City.

Section **VII. Eligibility and Enrollment of Members** is amended to include the following:

L. A Retiree Benefit Program is permissible under the parameters of the following criteria:

Retiree Group Health coverage is provided in accordance with the group Retirement Policy.

The Total Monthly Premium rates for Retirees, shown in Section **IX. Premium Payment** are effective from:

July 1, 2012 - June 30, 2013

For: Saint Mary's HealthFirst	For: City of Carson City
Dave Challis (signature)	____________________
Name: Dave Challis	Name: Robert L. Crowell
Title: Vice President and CFO	Title: Mayor
	Date ____________________

This is one (1) of two (2) originals

Saint Mary's Preferred Health Insurance Company, Inc.

City of Carson City

This Group Contract is executed by and between Saint Mary's Preferred Health Insurance Company, Inc. (hereinafter referred to as "SMPHIC"), and City of Carson City (hereinafter referred to as "Group").

WHEREAS, SMPHIC is organized and operating pursuant to the Nevada Revised Statutes, and;

WHEREAS, Group wishes to provide eligible employees with the opportunity to enroll in and receive health care services;

NOW THEREFORE, the parties hereto have set their hand and mutually agree as follows:

I. Definitions

A. **Anniversary** means the date, every twelve (12) months upon which the coverage under Certificate of Coverage (hereinafter referred to as "COC") renews for another twelve (12) month period.

B. **Health Benefit Plan** means the SMPHIC COC and any and all Attachments and Riders selected by the Group which is offered to eligible employees.

C. **Grace Period** means the time after the date that a premium is due during which the premium can be paid without penalty to keep the policy in force.

D. **Group** means an employer or other party who has executed a Group Contract with SMPHIC, through which health benefits are made available to eligible employees and the employer has agreed to collect and pay premiums.

E. **Group Contract** (hereinafter referred to as "Contract") means this document between the Group and SMPHIC and any attachments hereto, through which the health benefit plan for eligible employees and dependents is elected.

F. **Initial Group Open Enrollment Period** means the enrollment period established by the Group and SMPHIC prior to the effective date during which eligible persons may enroll in the health plan. The initial enrollment period will be a period of no less than fifteen (15) days in which all eligible persons must enroll or waive their right to coverage. Subsequent Open Enrollment Periods will be held every twelve (12) months from the initial effective date of the Group's coverage.

G. **Premium** means the periodic payment, usually monthly, made to SMPHIC by the Group on behalf of eligible enrolled employees, which entitles those employees and dependents to the health benefit plan detailed in Section III of this contract.

SMPHIC will provide the Group with an acknowledgment in the Form of a Written Notice of Contract Termination ("Notice"). Promptly upon receipt of the Notice, Group will mail via First Class U.S. Mail to each Member a legible copy of the notice. Group agrees to provide SMPHIC with written proof of that mailing and of the date thereof. If the terms of this Contract are altered by consent of both parties, no resulting reduction in coverage will adversely affect a Member who is confined to a hospital at the time of such change.

Termination on notice

Group may terminate this Contract:

1. for any reason, effective the day before any anniversary of July 1st (the "Anniversary Date") by giving at least thirty (30) days prior written notice to SMPHIC;

2. upon written notice within thirty (30) days of notice of an increase in the Total Monthly Premium;

and remitting all amounts payable relating to this Contract, including Premiums, for the period prior to the termination effective date.

Good Cause for termination or not renewing by SMPHIC shall include:

1. **Non Payment**
   Failure of Group to pay the premium for this Contract when due or within the thirty (30) day grace period. If a premium is not paid by the end of the grace period, SMPHIC may terminate the contract of insurance retroactively to the end of the day preceding the grace period. Cancellation will not be effective until at least ten (10) days after SMPHIC has delivered or mailed written notice to the group.

2. **Material Breach of COC requirements**
   For any material breach of terms detailed in the COC upon sixty (60) days notice to Group.

3. **Fraud, Noncompliance or intentionally furnishing incorrect or incomplete information**
   SMPHIC may terminate this Contract upon fifteen (15) days prior written notice to Group if:

   A. Group fails to comply with its material obligations under this Contract (including but not limited to its obligations under the "Eligibility and Enrollment" section of this Contract), or

   B. Knowing failure by the employer to abide by and enforce the conditions of enrollment of Members as set forth in the "Eligibility and Enrollment" provisions of the COC and the Employer Application, or

   C. Has performed an act that constitutes fraud or misrepresents or intentionally furnishes incorrect or incomplete material information (including but not limited to the employees covered under the plan or other information regarding eligibility for coverage under the plan).

VI. Amendment of Contract

This Contract may be amended by mutual agreement of the Group and SMPHIC. All amendments shall be in writing and shall be attached to and become a part of the entire Contract.

Upon sixty (60) days prior written notice to Group, SMPHIC may amend this Contract effective as of the next Anniversary Date. If SMPHIC has not received all necessary government approval of its Premium rates by the date it gives notice under this section, SMPHIC will notify Group of the Premium rates for which it has sought government approval. SMPHIC may then amend this Contract with respect to Premium rates by giving notice to the Group after receiving all necessary government approval, in which case the Premium rates go into effect as of the next Anniversary Date.

In addition to amendments effective as of an Anniversary Date, SMPHIC may, subject to government approval, amend this Contract at any time by giving notice to Group, in order to (a) comply with applicable law.

All amendments are deemed accepted by the Group unless the Group gives SMPHIC written notice of non-acceptance at least fifteen (15) days before the effective date of the amendment and remits all amounts payable related to this Contract, including Premiums, for the period prior to the amendment effective date. If the Group rejects the amendment, this Contract will automatically terminate as of the day before the effective date of the amendment.

VII. Eligibility and Enrollment of Members

A. Eligible Employees include:

1. a bona fide employee of the Group entitled to participate in the health care benefit program arranged by the Group or entitled to coverage under a Trust Agreement or employer contract;

2. those who satisfy any probationary or waiting period requirements established by the Group and who enroll within thirty-one (31) days of their eligibility date.

B. Special Enrollments

Employees who decline coverage for themselves or their dependents, for any reason, and later decide that they want coverage will not be eligible until the next open enrollment period unless, the employee has (1) creditable health coverage within the meaning of 26 USC § 9801 and (2) has lost coverage as a result of:

1. termination of employment or eligibility;

2. involuntary termination of the creditable coverage;

3. death of a spouse, or divorce.

H. Group will provide for the distribution of pertinent SMPHIC health benefit plan information to eligible employees. The SMPHIC staff will be given the opportunity to answer employee questions and to provide additional information during the Initial Enrollment and all subsequent Group Enrollment Periods.

I. Group will allow SMPHIC to review and audit payroll and other pertinent records for the verification of eligibility of employees. SMPHIC will make written request to Group and conduct all such interviews during regular business hours.

J. Age Banded Rates are rates determined by the age and sex of the eligible employee or eligible spouse. Members move to the rate corresponding to the appropriate age band on the month following their birthday, and not on renewal.

K. **For a group with 6 or more** eligible employees, <u>seventy-five percent</u> (75%) of all eligible employees must enroll in the group health plan or demonstrate other creditable coverage. Those eligible employees waiving with creditable coverage will not be a factor in determining the group participation. **For groups with 2-5** eligible employees, <u>one hundred percent</u> (100%) of eligible employees must enroll or show creditable coverage.

VIII. Termination of Coverage

Termination due to Nonpayment

Only a Member, and his or her enrolled dependents, for whom SMPHIC has received the appropriate payment listed in the Premiums section are entitled to coverage under this Contract. If Group fails to make any past-due payment for a Member within thirty (30) day grace period, SMPHIC may terminate the Member in accord with the "Termination of Coverage" section of the COC. In addition, Group is liable for all unpaid Premiums for the Member through the termination date.

The Group may be required to continue coverage for an employee or dependent who has lost eligibility within the Group. The specific option for continuation will be determined by the individual employee or dependent qualifying event as detailed in the COC. The Employee and their dependents will be terminated off of the group plan on the after termination of employment.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage

SMPHIC recognizes that many employers must comply with the continuation of group coverage requirements of federal laws and regulations, which collectively are commonly referred to as Consolidated Omnibus Budget Reconciliation Act (COBRA) (hereinafter referred to as "COBRA"). SMPHIC acknowledges that employers who are so affected cannot discharge their legal obligations without SMPHIC's informed and willing participation in providing the continuation coverage. SMPHIC is therefore committed to the following:

A. Maintaining awareness of continuation coverage requirements of the Internal Revenue Code, the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act and regulations, which are issued by the Secretaries of these agencies.

IX. Premium Payment

A. Group agrees to remit to SMPHIC the Total Monthly Premium on behalf of each eligible employee who has enrolled in the health benefit plan, in accordance with the Class of Contract and Total Monthly Premium listed herein. Where applicable, any contribution required by the employee will be collected through payroll deduction or other such program by the Group. Only Members for which the SMPHIC has received the appropriate payment are entitled to services and supplies.

Tier: Retiree	Medical	Rx	Dental	Vision	Total Monthly Premium
Single without Medicare	$439.76	$102.41			$542.16
Single with Medicare	$295.78	$102.41			$398.18
Retiree & One w/o Medicare	$944.81	$214.44			$1,159.25
Retiree & One both w/ Medicare	$635.47	$214.44			$849.91
Retiree & One one w/ Medicare	$790.14	$214.44			$1,004.58
Retiree & Family w/o Medicare	$1,250.76	$283.88			$1,534.65
Retiree & Family two with Medicare	$841.25	$283.88			$1,125.13
Retiree & Family one with Medicare	$1,045.66	$283.88			$1,329.55

Total Monthly Premium rates are effective from July 1, 2011 to June 30, 2012.

B. The Total Monthly Premium is billed to Group in advance of the month for which coverage is provided. Premium payments are due the first day of the month for the month in which coverage is provided. The charges shall be calculated by SMPHIC from current records as to the number of Members enrolled. Dues are payable for new Members for the entire month regardless of the effective date of enrollment or termination.

C. Premium adjustments required as a result of terminations or new hires will be applied by SMPHIC to the Premium Billing subsequent to the receipt of the required SMPHIC forms and notifications procedures. Retroactive payment adjustments will be made in subsequent billing statements for any additions or terminations of Members not reflected in SMPHIC's records at the time of calculation of Premium charges.

In order for a credit of Premium charges to be applied for terminated Members, SMPHIC must receive notification as soon as possible following the date of the Member's ineligibility, but in no event later than sixty (60) days following such date. SMPHIC will credit a maximum of sixty (60) days of Premium charges to the employer for ineligible Members.

It is the sole responsibility of the Group to review the Total Monthly Premium each month, ensure it accurately reflects any and all Member terminations, and bring any discrepancies to the attention of HealthFirst within sixty (60) days of the Member's ineligibility.

C. **Interpretation of Contract**
The laws of the State of Nevada shall be applied to interpretation of this Contract. Where applicable, the interpretation of this Contract shall be guided by the direct-service, group practice nature of SMPHIC's operations as opposed to a fee-for-service indemnity basis.

D. **Services Not Covered**
Services, treatments and procedures to induce or reverse voluntary elective sterilizations are not covered. Birth control drugs and devices including but not limited to IUD's are also not covered.

E. **Adoption of Policies**
SMPHIC may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Group Contract and the Certificate of Coverage.

F. **Group Agent or Broker**
SMPHIC recognizes that Group may work with an Agent/Broker of Record who arranges a variety of insurance programs for the Group. SMPHIC will work cooperatively with the Group's Agent/Broker of Record. The Agent/Broker of Record must hold the appropriate State of Nevada health insurance license, and be appointed with SMPHIC. The Group agrees to notify SMPHIC in writing of any changes in its Agent/Broker of Record. Current Agent/Broker of Record is: Tanna Prince, Lockton Companies.

G. **Attorney Fees and Costs**
If SMPHIC or Group institute(s) legal action against the other to collect any sums owed under this Contract, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

H. **Contract Providers**
SMPHIC will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform, of any health care provider that contracts with SMPHIC if Group may be materially and adversely affected thereby.

I. **Delegation of claims review authority**
SMPHIC is a named fiduciary to review claims under this Contract. Group delegates to SMPHIC the discretion to construe and interpret the terms of the COC and other disclosure statements as well to determine whether a Member is eligible for benefits. In making these determinations, SMPHIC has authority to review claims in accordance with the procedures contained in the COC and herein, and to construe this Contract to determine whether the Member is entitled to benefits.

J. **Member Information**
Group will inform enrollees of eligibility requirements for Members and when coverage becomes effective and terminates. If SMPHIC gives Group any information that is material to Members, Group will disseminate that information to Members by the next regular communication to them, but in no event later than thirty (30) days after Group receives the information. For purposes of this paragraph, "material" means information that a reasonable person would consider important in determining action to be taken.

Signature Page

When notice is required under this Contract, it shall be sent prepaid, first class US mail to:

SMPHIC:

Sales and Marketing Department
Saint Mary's Preferred Health
Insurance Company, Inc.
1510 Meadow Wood Lane
Reno, Nevada 89502

Group:

Robert L. Crowell
City of Carson City

201 North Carson Street, No.4
Carson City, Nevada 89701

Mediation Before Litigation
Group and SMPHIC agree to first mediate prior to resort to the courts, the disputes described below pursuant to the procedures set forth herein. Group understands that each Member/enrollee's participation in mediation before litigation is completely voluntary, and that by agreeing to mediate disputes relating to the Certificate of Coverage, the Health Plan or health care services provided by SMPHIC, the Member/enrollee has not foregone their right to resolve any such dispute in a court of law or equity. Group agrees that any claim Group may assert for alleged violation of any duty to a Member arising out of this Contract, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this Contract, irrespective of legal theory, shall be resolved by first submitting the dispute to mediation which shall be conducted by JAMS/Endispute (916) 921-5300. In the event the dispute is not resolved through mediation, the dispute shall be resolved in a court of law or equity.

For: Saint Mary's Preferred Health Insurance Company, Inc.

Name: Dave Challis

Title: Vice President and CFO

Date 7/1/11

For Group: City of Carson City

Name: Robert L. Crowell

Title: Mayor

Date 6·28·11

This is one (1) of two (2) originals

Saint Mary's Preferred Health Insurance Company, Inc.

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's Preferred Health Insurance Company, Inc. and City of Carson City.

Section **III. Products** is amended to read as such:

List each product available from the plan and the appropriate COC

Benefit Plan HC033

Riders Rx $10/40/60D

Section **IX. Premium Payment**, part A is amended to read as such:

A. Group agrees to remit to Preferred Health Insurance Company, Inc. the Total Monthly Premium on behalf of each eligible employee who has enrolled in the health benefit plan, in accordance with the Class of Contract and Total Monthly Premium listed herein. Where applicable, any contribution required by the employee will be collected through payroll deduction or other such program by the Group. Only Members for which the Preferred Health Insurance Company, Inc. has received the appropriate payment are entitled to services and supplies.

HC033

Tier: Retiree	Medical	Rx	Dental	Vision	Total Monthly Premium
Single without Medicare	$496.86	$81.30	$0.00	$0.00	$578.16
Single with Medicare	$330.32	$81.30	$0.00	$0.00	$411.62
Retiree & Spouse w/o Medicare	$1,018.56	$166.66	$0.00	$0.00	$1,185.22
Retiree & Spouse both w/ Medicare	$709.67	$166.66	$0.00	$0.00	$876.33
Retiree & Spouse one w/ Medicare	$888.58	$166.66	$0.00	$0.00	$1,055.24
Retiree & Child(ren) w/o Medicare	$953.47	$156.01	$0.00	$0.00	$1,109.48
Retiree & Child(ren) w/ Medicare	$939.47	$156.01	$0.00	$0.00	$1,095.48
Retiree & Family w/o Medicare	$1,557.15	$254.79	$0.00	$0.00	$1,811.94
Retiree & Family two with Medicare	$781.77	$254.79	$0.00	$0.00	$1,036.56
Retiree & Family one with Medicare	$978.86	$254.79	$0.00	$0.00	$1,233.64

These Total Monthly Premium rates are effective from:

July 1, 2012 - June 30, 2013

Saint Mary's Preferred Health Insurance Company, Inc.

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's Preferred Health Insurance Company, Inc. and City of Carson City.

Section **III. Products** is amended to read as such:

List each product available from the plan and the appropriate COC

Benefit Plan HC033

Riders Rx $10/40/60D

Section **IX. Premium Payment**, part A is amended to read as such:

A. Group agrees to remit to Preferred Health Insurance Company, Inc. the Total Monthly Premium on behalf of each eligible employee who has enrolled in the health benefit plan, in accordance with the Class of Contract and Total Monthly Premium listed herein. Where applicable, any contribution required by the employee will be collected through payroll deduction or other such program by the Group. Only Members for which the Preferred Health Insurance Company, Inc. has received the appropriate payment are entitled to services and supplies.

HC033 **Tier: Retiree**	**Medical**	**Rx**	**Dental**	**Vision**	**Total Monthly Premium**
Single without Medicare	$496.86	$81.30	$0.00	$0.00	$578.16
Single with Medicare	$330.32	$81.30	$0.00	$0.00	$411.62
Retiree & Spouse w/o Medicare	$1,018.56	$166.66	$0.00	$0.00	$1,185.22
Retiree & Spouse both w/ Medicare	$709.67	$166.66	$0.00	$0.00	$876.33
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Retiree & Family one with Medicare	$978.86	$254.79	$0.00	$0.00	$1,233.64

These Total Monthly Premium rates are effective from:

July 1, 2012 - June 30, 2013

Saint Mary's Preferred Health Insurance Company, Inc.

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Amendment to the Group Contract is executed by and between Saint Mary's Preferred Health Insurance Company, Inc. and City of Carson City.

Section **VII. Eligibility and Enrollment of Members,** Part E reads as:

All eligible employees must satisfy any probationary or waiting period requirements established by the Group:

First of month following ninety (90) days of employment

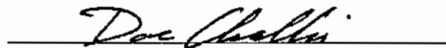
Section **VII. Eligibility and Enrollment of Members**, Part E amended to read as follows:

All eligible employees must satisfy any probationary or waiting period requirements established by the Group:

First of month following ninety (90) days of employment
Rehires: no waiting period for any employee laid off and rehired within a year.

This amendment will become effective April 1, 2012.

For: Saint Mary's Preferred Health Insurance Company, Inc.



Name: Dave Challis

Title: Vice President and CFO

For: City of Carson City

____

Name: Robert L. Crowell

Title: Mayor

Date:____________________

This is one (1) of two (2) originals

Saint Mary's Preferred Health Insurance Company, Inc.

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

This Addendum to the Group Contract is executed by and between Saint Mary's Preferred Health Insurance Company, Inc. and City of Carson City.

Section **III. Products** is amended to add:

List each product available from the plan and the appropriate COC

Riders Domestic Partner Rider

Section **VII. Eligibility and Enrollment**, part C is amended to read as such:

C. Dependents include:

1. employee's lawful spouse; or certified domestic partner:

This amendment is effective from:

July 1, 2012

For: Saint Mary's Preferred Health Insurance Company, Inc.	For: City of Carson City
[signature]	
Name: Dave Challis	Name: Robert L. Crowell
Title: Vice President and CFO	Title: Mayor
	Date ____________

This is one (1) of two (2) originals

Saint Mary's Preferred Health Insurance Company, Inc.

ADDENDUM TO THE GROUP CONTRACT OF:

City of Carson City

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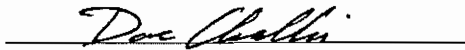
- City of Carson Police and Fire are eligible for retirement after 25 years of service

- All other City of Carson Employees are eligible for retirement after 30 years of service

The Total Monthly Premium rates for Retirees, shown in Section **IX. Premium Payment** are effective from:

July 1, 2012 - June 30, 2013

For: Saint Mary's Preferred Health Insurance Company, Inc.	For: City of Carson City
	______________________
Name: Dave Challis	Name: Robert L. Crowell
Title: Vice President and CFO	Title: Mayor
	Date ______________________

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Saint Mary's Preferred Health Insurance Company, Inc.

ADDENDUM TO THE GROUP CONTRACT OF:

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This Addendum to the Group Contract is executed by and between Saint Mary's Preferred Health Insurance Company, Inc. and City of Carson City.

Section **VII. Eligibility and Enrollment of Members** is amended to include the following:

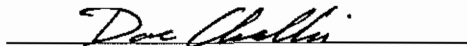
L. A Retiree Benefit Program is permissible under the parameters of the following criteria:

Retiree Group Health coverage is provided in accordance with the group Retirement Policy.

The Total Monthly Premium rates for Retirees, shown in Section **IX. Premium Payment** are effective from:

July 1, 2012 - June 30, 2013

For: Saint Mary's Preferred Health Insurance Company, Inc.



Name: Dave Challis

Title: Vice President and CFO

For: City of Carson City

____

Name: Robert L. Crowell

Title: Mayor

Date ________________________

This is one (1) of two (2) originals

Amendment No. 1
Saint Mary's HealthFirst Group Contract
City of Carson City

In accordance with Article VI of the Contract executed by and between Saint Mary's HealthFirst and City of Carson City ("Group"), on July 1, 2011, the parties mutually agree to amend the Contract as follows:

1. Term of Contract.

Section IV of the Group Contract is amended to state:

> This Contract becomes effective on July 1, 2011 at 12:00 a.m. Pacific Time and will remain in effect for a term of (seventy-two) 72 consecutive calendar months, until June 30, 2017 (the "Termination Date") unless earlier terminated pursuant to the Termination of Contract section (below). Except as expressly provided otherwise in any EOC document(s) incorporated into this Contract by reference, all rights to benefits under this Contract expire and will have no further force or effect as of 11:59 p.m. as of the Termination Date.

2. Termination of Contract

Section V of the Group Contract is hereby amended to state:

> The Group and HealthFirst have agreed to a six (6) year contract with annual pricing adjustments as specified below. HealthFirst and/or Group may only terminate this Contract for good cause on or before June 30, 2017 at 11:59 p.m. (the "Termination Date") as set forth below:
>
> In the event the Contract is terminated for Good Cause (described below), HealthFirst will provide the Group with an acknowledgment in the Form of a Written Notice of Contract Termination ("Notice"). Promptly upon receipt of the Notice, Group will mail via First Class U.S. Mail to each Member a legible copy of the notice. Group agrees to provide HealthFirst with written proof of that mailing and of the date thereof. If the terms of this Contract are altered by consent of both parties, the parties agree no resulting reduction in coverage or benefits will adversely affect a member who is confined to a hospital at the time of such change.
>
> **Good Cause** for Contract termination by Group shall mean:
>
> 1. **Significant change in the HealthFirst provider network**
>
>   Should HealthFirst experience a decrease of thirty percent (30%) or more in the number of physicians available in the HealthFirst network in the Carson City, Minden, Gardnerville and Dayton areas combined, the Group may terminate this Contract upon sixty (60) days prior written notice to HealthFirst.

4. **Failure to meet Participation and Contribution requirements**
Failure of the employer to maintain minimum subscription charge contribution requirements or minimum participatory requirements or as stated in the group requirements set forth in the Master Application (see Section VII, item L of this contract).

Group will allow HealthFirst to review and audit payroll and other pertinent records for the verification of eligibility of employees as stated in contributions or group requirements. HealthFirst will make written and verbal request to Group and conduct all such reviews during regular business hours.

Group agrees to pay **HealthFirst a minimum of 50% of the insurance premium** for all Group employees.

5. **Discontinuance of a product or all products within a market**
HealthFirst may terminate a particular product or all products offered in a small or large group market, if it discontinues offering insurance in the geographic area of the state where the employer is located. HealthFirst may also discontinue the issuance and renewal of coverage to a small employer if the Nevada Insurance Commissioner finds that the continuation of coverage would not be in the best interest of the policyholders or certificate holders or would impair the ability of the carrier to meet its contractual obligations. If the Commissioner makes such a finding, the Commissioner shall assist the affected small employers in finding replacement coverage. HealthFirst may also discontinue products offered to small employers if the Nevada Insurance Commissioner finds that the form of the product offered by HealthFirst is obsolete and is being replaced with comparable coverage. HealthFirst will notify the Commissioner and the Chief Regulatory Officer for insurance in each state in which it is licensed of its decision to discontinue the issuance or renewal of a product at least sixty (60) days before HealthFirst notifies the affected small employers. HealthFirst will notify affected employers at least one hundred eighty (180) days before the date on which it will discontinue offering the product and it will offer each affected small employer the option to purchase any other health benefit plan currently offered by it to small employers in Nevada. In exercising its option to discontinue the product and in offering the option to purchase other coverage, HealthFirst will act uniformly without regard to the claims experience of the affected small employers or any health status-related factor relating to any participant or beneficiary covered by the discontinued product or any new beneficiary who may become eligible for such coverage. HealthFirst will comply with the requirements of NRS 689C.310-.320 and NRS 689B.560 if it decides to discontinue providing insurance in a geographic area or discontinue products to the small employer market.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00% - 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00% - 89.99%	9.00%
90.00% - 94.99%	12.00%
> 95.00%	(See Note 1)

Year 3: The July 1, 2014 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2014 with claims experience from December 1, 2012 through November 30, 2013. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00% - 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00% - 89.99%	9.00%
90.00% - 94.99%	12.00%
> 95.00%	(See Note 1)

Year 4: The July 1, 2015 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2015 with claims experience from December 1, 2013 through November 30, 2014. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

4. Confidentiality.

As part of the consideration for Saint Mary's HealthFirst to enter into this Agreement, Group agrees that it shall not use, or divulge to anyone, Saint Mary's HealthFirst's trade secrets. A trade secret means information, including, but not limited to, programs, methods, techniques and processes, that has independent economic value from not being generally known to either the public or to other persons who can obtain economic value from its disclosure or use. Example of Saint Mary's HealthFirst's trade secrets include, but are not limited to, actual and potential membership lists, fee schedules, billing rates, compiled information concerning its beneficiaries, key provider agreements, and administrative manuals. This paragraph does not apply to information that is already in the public domain or that has been made available to the public by Saint Mary's HealthFirst.

For Saint Mary's HealthFirst:

Name: Dave Challis

Title: Vice President and CFO

Date: 8/12/11

For Group: City of Carson City

Name: Robert L. Crowell

Title: Mayor

Date: 6/9/11

SFI-582158v1

3. **Multiple Group Identification Numbers** – If there are multiple Group identification numbers used by Group, Group shall separate the information described in Item 3 by unique Group identification numbers.

4. **Changes to Self-Billing Reporting Format** – Saint Mary's may in its sole discretion, change the Reporting format requirements, described in Item 3 above, by providing Group with 60-days' advance written notice.

5. **Attestation** – Each month Group will submit their Self-Billing Report and it shall be acknowledged by Health Plan and Group as a declaration and attestation by Group that all employees listed on the Self-Billing Report have been properly enrolled for the month being reported. Any prospective change in the amount of an Eligible Employee's premium, due to a change in status, requires Group to timely file an appropriate change form with Health Plan.

6. **Premium Adjustments** – Group agrees that any premium adjustments required as the result of the termination of employment of employees or the hiring of new employees not previously shown on a Self-Billing Report shall be made by Group within the time frame described in the Group Contract.

7. **When Employee Coverage Ends** – Group agrees that an Eligible Employee's coverage shall end as of the last day of the month immediately preceding the Self-Billing Report which no longer shows the Eligible Employee as an Eligible Employee for coverage, unless a Termination Date is indicated during a reporting month on a Self-Billing report submitted by Group.

8. **Employees Not Listed Are Not Covered** – Group agrees that any Eligible Employee not listed on the Self-Billing Report certifies to Health Plan that the Employee is no longer eligible for coverage. No other formal notice terminating an Eligible Employee's coverage is required.

Agreed and Accepted

For Saint Mary's Preferred Health Insurance Company, Inc.

Name: Dave Challis

Title: Vice President and CFO

Date: 8/12/11

For Group: City of Carson City

Name: Robert L. Crowell

Title: Mayor

Date: 8-8-11

3. **Multiple Group Identification Numbers** – If there are multiple Group identification numbers used by Group, Group shall separate the information described in Item 3 by unique Group identification numbers.

4. **Changes to Self-Billing Reporting Format** – Saint Mary's may in its sole discretion, change the Reporting format requirements, described in Item 3 above, by providing Group with 60-days' advance written notice.

5. **Attestation** – Each month Group will submit their Self-Billing Report and it shall be acknowledged by Health Plan and Group as a declaration and attestation by Group that all employees listed on the Self-Billing Report have been properly enrolled for the month being reported. Any prospective change in the amount of an Eligible Employee's premium, due to a change in status, requires Group to timely file an appropriate change form with Health Plan.

6. **Premium Adjustments** – Group agrees that any premium adjustments required as the result of the termination of employment of employees or the hiring of new employees not previously shown on a Self-Billing Report shall be made by Group within the time frame described in the Group Contract.

7. **When Employee Coverage Ends** – Group agrees that an Eligible Employee's coverage shall end as of the last day of the month immediately preceding the Self-Billing Report which no longer shows the Eligible Employee as an Eligible Employee for coverage, unless a Termination Date is indicated during a reporting month on a Self-Billing report submitted by Group.

8. **Employees Not Listed Are Not Covered** – Group agrees that any Eligible Employee not listed on the Self-Billing Report certifies to Health Plan that the Employee is no longer eligible for coverage. No other formal notice terminating an Eligible Employee's coverage is required.

Agreed and Accepted

For Saint Mary's Preferred Health Insurance Company, Inc.

Name: Dave Challis

Title: Vice President and CFO

Date: ______________

For Group: City of Carson City

Name: Robert L. Crowell

Title: Mayor

Date: 8-8-11

SF:296814.2 Rev

2. **Fraud, Noncompliance or intentionally furnishing incorrect or incomplete information**

   Group may terminate this Contract upon fifteen (15) days prior written notice to SMPHIC if:

   A. SMPHIC knowing fails to provide services as specified in the provisions of the COC, or

   B. SMPHIC has performed an act that constitutes fraud or knowingly furnishes Group with materially false information.

Good Cause for termination by SMPHIC shall include:

1. **Non Payment**
   Failure of Group to pay the premium for this Contract when due or within the thirty (30) day grace period. If a Premium is not paid by the end of the grace period, SMPHIC may terminate the contract of insurance retroactively to the end of the day preceding the grace period. Cancellation will not be effective until at least ten (10) days after SMPHIC has delivered or mailed written notice to the group.

2. **Material Breach of COC requirements**
   For any material breach of the terms detailed in the COC, upon sixty (60) days notice to Group.

3. **Fraud, Noncompliance or intentionally furnishing incorrect or incomplete information**
   SMPHIC may terminate this Contract upon fifteen (15) days prior written notice to Group if:

   A. Group fails to comply with its material obligations under this Contract (including but not limited to its obligations under the "Eligibility and Enrollment" section of this Contract), or

   B. Knowing failure by the employer to abide by and enforce the conditions of enrollment of Members as set forth in the "Eligibility and Enrollment" provisions of the COC and the Employer Application, or

   C. Has performed an act that constitutes fraud or misrepresents or intentionally furnishes incorrect or incomplete material information (including but not limited to the employees covered under the plan or other information regarding eligibility for coverage under the plan).

6. **A Material change in the nature of the Employer's Business Affecting Underwriting**
   - An annual change of thirty percent (30%) or more in the number of eligible employees which would materially change underwriting for the Group.
   - Other significant changes in the composition or status of the employer's business.

3. **Pricing.**

The pricing for the July 1, 2011 to June 30, 2012 period will be as specified in the Group Contract. After the initial year of the contract, the pricing for the five subsequent years of the contract period will be determined as follows:

Year 1: The July 1, 2012 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2012 with claims experience from December 1, 2010 through November 30, 2011. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00% - 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00% - 89.99%	9.00%
90.00% - 94.99%	12.00%
> 95.00%	(See Note 1)

Year 2: The July 1, 2013 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2013 with claims experience from December 1, 2011 through November 30, 2012. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00% - 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00% - 89.99%	9.00%
90.00% - 94.99%	12.00%
> 95.00%	(See Note 1)

Year 5: The July 1, 2016 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2016 with claims experience from December 1, 2014 through November 30, 2015. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00% - 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00% - 89.99%	9.00%
90.00% - 94.99%	12.00%
> 95.00%	(See Note 1)

Note 1: For any Loss Ratio greater than 95%, the parties will negotiate in good faith to determine a mutually agreeable increase. If a mutually agreeable increase cannot be reached, then the parties may terminate the agreement. If Saint Mary's Health Plan unilaterally agrees to an increase of 12.0% or less when the Loss Ratio is greater than 95%, then this five year arrangement remains intact.

Saint Mary's Health Plans

A member of CHW

Large Group Renewal Election Form

Group Name:	City of Carson	Date renewal issued:	February 16, 2012
Renewal Effective Date:	**July 1, 2012**	Broker Name:	Tanna Prince/Lockton
Group Number(s):	GRP0004227	Account Manager:	Joyce Toste

Please return the signed Renewal Election Form no later than the 5th of the month **prior** to the renewal. Changes may not be reflected on the renewal billing statement if received after the requested date. All renewals are contingent upon meeting the underwriting guidelines of Saint Mary's Health Plans.

PLEASE INDICATE HERE IF YOU WISH TO MAINTAIN YOUR CURRENT PLAN FOR GRANDFATHER STATUS:

YES N/A NO X

Please write the selected plan names below

Medical plan design	HMO Beyond 100% 3030	1500 POS 1030/2040	1XHC033
Rates	See Attachment		
Pharmacy design	$10/40/60D	$10/40/60D	$10/40/60D
Rates	See Attachment		

<u>OPTIONAL RIDERS:</u>

Family Planning plan (FPP 1, 2 or 3)	FPP #3	Rate	See Attachment
Dental plan (Dental 1, 2 or 3)	None	Rate	________
Vision (yes or no)	None	Rate	________

Only one Family Planning, Dental, and Vision Rider may be selected. The selected rider(s) will be applied to all medical/Rx plan options.

Domestic Partner as eligible dependent Yes______ No______

Employer Contributes the following amounts for: Employee: ______% Dependents: ______%

After reviewing the renewal rates and selecting the plans shown above, we confirm that we intend to renew our health insurance benefit plan(s) through Saint Mary's Health Plans effective on our renewal date.

We also acknowledge that we understand the signed Renewal Election Form must be received prior to the renewal effective date to avoid a disruption in coverage.

______________________________ ______________________________

Company Authorized Representative (please print) (Date)

______________________________ ______________________________

Title Please provide email address

____

Signature

Please email signed completed form to joyce.toste@dignityhealth.org

Alive with possibilities.

VISION SERVICE PLAN, INC.
GROUP VISION CARE PLAN
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which its Enrollees or members, and their Eligible Dependents are entitled to become Covered Persons of VSP and receive Plan Benefits in accordance with the terms of such Plan.

1.14. **KERATOCONUS**: A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

1.15. **MEMBER DOCTOR**: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

1.16. **NON-MEMBER PROVIDER**: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

1.17. **PLAN ADMINISTRATOR**: The person specifically so designated on the application, or if an administrator is not so designated, the Group. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Group.

1.18. **PLAN BENEFITS**: The vision care services and vision care materials that Covered Person is entitled to receive by virtue of coverage under this Plan, as defined in the Schedule of Benefits attached hereto as Exhibit A.

1.19. **PREMIUMS**: The payments made to VSP by Group on behalf of Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached hereto as Exhibit B.

1.20. **RENEWAL DATE**: The date on which the Plan shall renew, or expire if proper notice is given.

1.21. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A, that lists the vision care services and vision care materials that Covered Person is entitled to receive by virtue of coverage under this Plan.

1.22. **SCHEDULE OF PREMIUMS**: The document, attached hereto as Exhibit B, which states the payments to be made to VSP by or on behalf of Covered Person to entitle him/her to Plan Benefits.

SECTION III.
OBLIGATIONS OF VSP

3.01. **Coverage of Covered Persons**: VSP will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, Group may be required by VSP to complete and sign a Group Application and forward such application to VSP, along with information regarding Enrollees and Eligible Dependents, and all applicable Premiums. (Refer to Section VI. Eligibility For Coverage for further details.)

Following the enrollment of the Covered Person, VSP will make available to all Covered Persons a Member Benefit Summary. Such Member Benefit Summary will summarize the terms and conditions set forth in this Plan.

3.02. **Provision of Plan Benefits**: Through its Member Doctors (or through other licensed vision care providers where the Covered Person chooses to receive Plan Benefits from a Non-Member Provider), VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A hereto), subject to any limitations, exclusions, or Copayments therein stated. When the Covered Person desires to receive Plan Benefits from a Member Doctor, the Covered Person shall contact VSP or the Member Doctor. VSP shall provide Benefit Authorization to the Member Doctor or to the eligible Covered Person for use in receiving Plan Benefits from a Member Doctor. Benefit Authorization shall be issued by VSP in accordance with the latest eligibility information furnished by Group and past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the Member Doctor that payment will be made. VSP shall not be held liable to Group for any Benefit Authorizations so issued in error. Covered Persons are required to obtain the Benefit Authorization prior to obtaining Plan Benefits in cases where the Covered Person obtains Plan Benefits from a Member Doctor (see Section 5.03 for further details).

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP has received a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

SECTION IV.
OBLIGATIONS OF THE GROUP

4.01. Identification of Eligible Enrollees: An Enrollee is eligible for coverage under this Plan if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by VSP and Group. By the effective date of this Plan, Group shall provide VSP with a listing, in a form approved by VSP, of all of its Enrollees who are eligible for coverage under this Plan as of that date and a designation of family status for each such Enrollee, if dependent coverage is provided. Thereafter, Group shall supply to VSP on or before the last day of each month, in a form approved by VSP, a listing of all Enrollees with a designation of family status who will be added to or deleted from VSP's coverage rosters for the succeeding month.

4.02. Payment of Premiums: On or before the first day of each month, Group shall remit to VSP the premiums payable for the succeeding month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Plan for such succeeding month. The amount of such Premiums for each Covered Person shall be as provided in the Schedule of Premiums incorporated in this Plan as Exhibit B. Only Covered Persons for whom Premiums are actually received by VSP shall be entitled to Plan Benefits hereunder and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Covered Person is not received by the time specified above, VSP reserves the right to terminate all rights of such Covered Person, and such rights may be reinstated only in accordance with the requirements of this Plan.

VSP may change the Premiums shown on the attached Schedule of Premiums, (Exhibit B) by giving Group at least sixty (60) days advance written notice. VSP may change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Plan are changed. No change will be made during the Plan Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan. No change will be made more often than once during any twelve (12) month period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan.

Notwithstanding the above, VSP reserves the right to increase Premiums required hereunder by the amount of any tax or assessment not now in effect which is subsequently levied by any taxing authority, which is attributable to the Premiums VSP receives from Group.

SECTION V.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

5.01. <u>General</u>: By this Plan, Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, this Plan may be amended or terminated by agreement between VSP and Group without the consent or concurrence of the Covered Persons. This Plan, and all Exhibits, attachments and amendments attached hereto constitute VSP's sole and entire undertaking to Covered Persons under this Plan.

All Covered Persons under this Plan shall have the following obligations as a condition of their coverage.

5.02. **<u>Copayments for Services Received</u>**: Where, as indicated on the Schedule of Benefits, Exhibit A hereto, Copayments are required for certain Plan Benefits, these Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Member Doctor on the date the services are rendered.

5.03. **<u>Authorization of Services</u>**: The Covered Person must receive Benefit Authorization before receiving Plan Benefits from a Member Doctor. Such Benefit Authorization is received by contacting a Member Doctor or VSP. Should the Covered Person receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the provider will be considered a Non-Member Provider, and the benefits available will be limited to those for a Non-Member Provider, if any.

5.04. **<u>Complaints and Grievances: Time of Action</u>**: Covered Persons shall report any complaints and/or grievances to VSP at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to VSP verbally or in writing. Covered Person may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

5.05. <u>Insurance Fraud</u>: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

6.02. Documentation of Eligibility: Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:

(a) for an Enrollee, the individual's name and Social Security Number have been reported by Group to VSP in the manner provided hereunder; and

(b) in the case of changes to a Dependent's status, the change has been reported by the Group to VSP in the manner provided herein.

As stated in Section 4.04. herein, VSP may elect to inspect the Group's records in order to verify eligibility of Enrollees and Dependents. Plan Benefits will be available only to persons on whose behalf Premiums have been paid for the current period, or grace periods outlined herein in Section 4.03. If a clerical error is made, it will not affect the coverage to which the Covered Person is entitled under the Plan.

6.03. Change of Participation Requirements, Contribution of Fees, and Eligibility Rules: Composition of the Group, percentage of Enrollees covered under the Plan, and eligibility requirements are material to VSP's obligations under this Plan. During the term of this Plan, Group may not change its composition, percentage of Enrollees covered, or eligibility requirements in any way that affects VSP's obligations hereunder unless VSP consents to such change in writing. VSP may require the Group to make written request for any such change at least sixty (60) days prior to the proposed effective date of the change. Nothing herein shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Plan.

6.04. Change in Family Status: In the event of any change in the Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of dependent children, etc.], written notice in a form acceptable to VSP is to be given to VSP by the Covered Person, or by someone else acting on the Covered Person's behalf, within thirty-one (31) days of such change. If such notice is given, the change in the Covered Person's status will become effective on the first day of the month following the request for change, or at such later date as may be requested by or on behalf of the Covered Person. A natural or adopted newborn will be covered from the moment of birth when timely notice of the addition is given.

SECTION VIII.
CLAIMS DENIAL APPEALS AND ARBITRATION OF DISPUTES

8.01. Claims Denial Appeals: If, under the terms of this Plan, a claim is denied in whole or in part, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) Initial Appeal: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the Enrollee's name, the Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

b) Second Level Appeal: If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) Other Remedies: When Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Group should advise Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

SECTION IX.
NOTICES

9.01. **Notice**: Any notices required to be given under this Plan to either Group or VSP shall be in writing and delivered by United States First Class Mail. Notices sent to Group will be mailed to the address shown on the Group Application. Notices sent to VSP shall be sent to the address shown on this Plan. Any notices may be hand-delivered by either party to an appropriate representative of the party, with the burden being on the party effecting such hand-delivery, to prove, if questioned, that such delivery was made.

10.08. **Gender**: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

10.09. **Equal Opportunity Employer**: All communication materials created by Group that relate to this vision care Plan must be approved by VSP in advance of mailing to Enrollees.

10.10. **Communication Materials**: All communication materials created by Group that relate to this vision care Plan must be approved by VSP in advance of mailing to Enrollees.

10.11. **Replacement of Coverage**: Replacement coverage of vision benefits provided within a period of sixty (60) days from the date of discontinuance of a prior policy providing vision benefits shall immediately cover all Enrollees and Eligible Dependents validly covered under the previous plan at the date of discontinuance who are within the definitions of eligibility and who would otherwise be eligible for coverage under the succeeding carrier's plan, regardless of any limitations or exclusions relating to active employment or non-confinement.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in Full*	Up to $ 50.00*
Bifocal	Covered in Full*	Up to $ 75.00*
Trifocal	Covered in Full*	Up to $ 100.00*
Lenticular	Covered in Full*	Up to $ 125.00*

*Less any applicable Copayment

Available once every 12 months.

Frames	Covered up to Plan Allowance*	Up to $ 70.00*

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

*Less any applicable Copayment.

Available once every 24 months.

Lenses and frames include such professional services as are necessary, which shall include:

Prescribing and ordering proper lenses;
Assisting in the selection of frames;
Verifying the accuracy of the finished lenses;
Proper fitting and adjustment of frames;
Subsequent adjustments to frames to maintain comfort and efficiency;
Progress or follow-up work as necessary.

COPAYMENT

The benefits described above are available to each Covered Person from any participating Member Doctor at no cost to the Covered Person, with the exception of any applicable Copayment as described below.

There shall be a Copayment of $25.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

LOW VISION BENEFIT

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplementary Testing	Covered in Full	Up to $125.00*

Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplementary Care	75% of Cost	75% of Cost*

Subsequent low vision therapy.

Copayment

75% of the benefits payable by the Company and 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is $1,000.00 (excluding Copayment) every two years.

***NON-MEMBER BENEFIT**

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his/her full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

Exhibit B

VISION SERVICE PLAN, INC.
SCHEDULE OF PREMIUMS
SIGNATURE PLAN

VSP shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$ 6.61	per month for each eligible Enrollee without dependents.
$ 8.59	per month for each eligible Enrollee with one eligible dependent.
$ 15.39	per month for each eligible Enrollee with two or more eligible dependents.

NOTICE: The premium under this Plan is subject to change upon renewal (after the end of the initial Plan Term or any subsequent Plan Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Plan.

PLAN BENEFITS

SERVICE*	MEMBER DOCTOR BENEFIT	BENEFIT FREQUENCY†	NON-MEMBER PROVIDER BENEFIT**
Ophthalmological services and Office Visits	Covered in full, less $20.00 Copayment	Once every 12 months	Up to current Non-Member Provider Schedule of Allowances
Gonioscopy	Covered in full	Once every 12 months	
Extended Ophthalmoscopy	Covered in full	Once every 6 months*	
Fundus Photography	Covered in full	Once every 6 months*	

COVERED SERVICES (The following list is current as of [7/1/08] and is subject to change without notice.)

Description	Procedure Code
Ophthalmological services	92002, 92004, 92012, 92014
Office Visits	99201 - 99205, 99211 - 99215
Gonioscopy	92020
Extended Ophthalmoscopy	92225, 92226
Fundus Photography	92250

*Service and/or diagnosis limitations apply, or certain procedures require special handling. Member Doctors must consult the *VSP ProviderReference Manual* for details before rendering services.

†Benefit frequency periods begin on the date of the first Ophthalmological Service or Office Visit.

**Non-Member Provider Benefits are available only to Covered Persons whose Group has purchased this option, or where such benefits are required by the laws of Covered Person's state of residence. Covered Persons should contact their Group, or VSP Customer Service at (800) 877-7195 before obtaining services from Non-Member Providers.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The DEP covers diabetic eyecare evaluation services only. There is no coverage provided under the Plan for the following:

- Costs associated with securing frames, lenses or any other materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
- Pathological treatment of any type for any condition.
- Any eye examination required by an employer as a condition of employment.
- Insulin or any medications or supplies of any type.
- Services and/or materials not included in this Rider as covered Plan Benefits.

TheStandard®

December 22, 2011

BARBARA PEACH
CITY OF CARSON CITY
201 N CARSON ST STE 4
CARSON CITY, NV 89701-4289

RE: Policy: 160-518194 Renewal Effective: 7/1/2012

Thank you for allowing Standard Insurance Company to provide quality products to support your employees' insurance needs. We are pleased to renew your policy with continued coverage and services.

We have carefully reviewed the current composition of your organization and evaluated the experience of your dental policy. Based upon this review and application of rate factors appropriate for your industry classification, we are renewing your policy at the existing premium rates as indicated in the chart below. These rates are guaranteed until July 1, 2013.

Division 3/Class 1

Dental Coverage	**Through 6/30/2012**	**Effective 7/1/2012**
Employee	$57.08 per member	$57.08 per member
Employee & One Dependent	$94.76 per member	$94.76 per member
Employee & 2 or more Dependents	$115.75 per member	$115.75 per member

If you have any questions about your rates or our review process our Employee Benefits Sales and Service office at 818-386-6200 is available to serve your needs. We value your business and welcome the opportunity to provide continued assistance to you.

Sincerely yours,

Kristin Wulser

Kristin Wulser
Group Insurance Underwriter
Employee Benefit Services
Standard Insurance Company

I request that the amendment, if approved and issued by The Standard, become effective by its terms without any further acceptance by the Employer, and that a copy of this Request for Group Insurance Amendment form be attached to and made a part of the amendment.

Sign Name: ______________________________ Title: ______________________________
Authorized Representative

Print Name: ______________________________ Date: ______________________________

I request that the amendment, if approved and issued by The Standard, become effective by its terms without any further acceptance by the Employer, and that a copy of this Request for Group Insurance Amendment form be attached to and made a part of the amendment.

Sign Name: ______________________________ Title: ______________________________
Authorized Representative

Print Name: ______________________________ Date: ______________________________

Request for Group Insurance Amendment

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1282

Employee Benefits Consultant: Jim Bauer
Employee Benefits Service Representative: Darin Plotnick
Employee Benefits Sales and Service Office: Los Angeles

Employer Name: City of Carson City
Group Number: 518194

As an authorized representative of the Employer, I request that Standard Insurance Company ("The Standard") amend the above Employer's coverage under the Group Policy to make the following change(s):

Please amend the Dental policy to have Major Dental Expenses to be paid at 55%. No rate impact for this change.

Please amend the Dental rates to a 4 tier rate structure. The rates, guaranteed for one year, will be:

EE $57.08
EE+SP $80.28
EE+CH $101.52
EE+FAM $124.72

I request that the amendment become effective on July 1, 2012. I understand that the amendment will not become effective unless approved and issued by The Standard.

I request that the amendment be approved by The Standard subject to The Standard's usual underwriting requirements, including, if applicable, Evidence of Insurability or a Pre-existing Condition provision.

I understand that the amendment, if approved by The Standard, will be issued in the policy language customarily used by The Standard.

I understand that any increase in Insurance for a Member who is not Actively At Work all day on the Member's last regular work day before the scheduled effective date of the amendment will be deferred until the first day after the Member completes one full day of Active Work.

I request that the amendment, if approved and issued by The Standard, become effective by its terms without any further acceptance by the Employer, and that a copy of this Request for Group Insurance Amendment form be attached to and made a part of the amendment.

Sign Name: ______________________ Title: ______________________
Authorized Representative

Print Name: ______________________ Date: ______________________

February 13, 2011

City of Carson City
Attn: Benefits Manager
201 N Carson St Suite 3
Carson City NV 89701

Group Number 602813

Thank you for allowing Standard Insurance Company to provide quality products to support your employees' insurance needs. We are pleased to renew your policy with continued coverage and services.

We have carefully reviewed the current composition of your organization, evaluating age, occupation, gender and salary of your insured employees. Based upon this review and application of rate factors appropriate for your industry classification, we are renewing your policy at existing premium rates as indicated in the chart below. These rates are guaranteed until July 1, 2014.

Insurance Coverage	***Through 06/30/12***	***Effective 07/01/12***
Basic Term Life	$0.41 Per $1000 of Benefit	$0.41 Per $1000 of Benefit
Basic AD&D	$0.04 Per $1000 of Benefit	$0.04 Per $1000 of Benefit
Dependents Life	$0.30 Per Member, Elective	$0.30 Per Member, Elective

If you have any questions about your rates or our review process, the Los Angeles Employee Benefits Sales and Service Office at (800) 524-0450 is available to serve your needs. We value your business and welcome the opportunity to provide continued assistance to you.

Sincerely yours,

Jon Franz
Western Risk Team 1
Employee Benefits Division
Standard Insurance Company

cc: Lockton Companies LLC
Los Angeles Employee Benefits Sales and Service Office
PSB-3A
CSLA, W
Contract file
Premium file